



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

BETHANY POWELL, MD  
3100 TIMMONS LANE, STE 250  
HOUSTON, TX 77027

#### **Respondent Name**

ACE AMERICAN INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 15

#### **MFDR Tracking Number**

M4-12-0441-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "CARRIER FAILED TO PAY THIS DESIGNATED DOCTORS EXAM EVEN AFTER IT WAS SENT BACK AS REQUEST FOR RECONSIDERATION. I CALLED THE ADJUSTER AND WAS TOLD THAT I NEEDED TO REMAIL THE CLAIM, ADVISED WAS ALREADY SENT TO CARRIER AND NO PAYMENT AND SCHEDULED TO GO TO MEDICAL DISPUTE AND WAS TOLD TO DO WHAT I NEEDED TO DO WITH THIS CLAIM."

**Amount in Dispute:** \$700.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Requestor has not included any EOBs with their submission and Carrier cannot confirm that Requestor's bills were received. Carrier is submitted the bill for audit and will supplement its position based on that audit."

**Response Submitted by:** Flahive, Ogden, & Latson, P.O.BOX 201320, Austin, TX 78720

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2011	99456-W5-WP AND 99456-MI	\$700.00	\$700.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:  
No Explanation of Benefits provided by either party.

### **Issues**

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

### **Findings**

1. There are no explanations of benefit(s) for this dispute provided by either party to the dispute. The respondent states in its response that it cannot confirm that the bills were received. The requestor shows that the billing was sent to the adjuster's fax number as provided on the DWC-32. Therefore, this MDFR will be reviewed according to the documentation provided and the applicable fee guidelines in 28 Texas Administrative Code §134.204.
2. The provider billed an amount of \$650.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR) and \$50.00 for CPT code 99456-MI for multiple IR. Review of the documentation supports that MMI was assigned and billed 1 body area/unit in box 24G on the CMS-1500. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is \$350.00. The narrative documentation was examined by MFDR to determine how the impairment ratings were performed and to which area/areas. Documentation supports that the evaluator compared two different ratings, one with compensable only and another with compensable plus additional rated areas that are not accepted as compensable at time of rating. As multiple impairments were rendered, the MAR for CPT 99456-MI is \$50.00 per 28 Texas Administrative Code §134.204 (j)(4)(B) which states:

When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code

For the compensable areas, range of motion (ROM) IR method on the left wrist (upper extremities) is rated for a MAR of \$300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). Alternatively, for the compensable plus non-compensable areas, the IR per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the non musculoskeletal condition of left wrist carpal tunnel syndrome is per 28 Texas Administrative Code §134.204 (j)(4)(D)(iv) and (v) with a MAR of \$150.00. Both methods cannot be counted for reimbursement. The resolved left forearm contusion was not documented as examined and therefore not reimbursable. Also, the left elbow was rated with an observed ROM which is not supported by measurements or tests, there is no reimbursement due. There was only one body area listed on the CMS-1500 reimbursement is for the left wrist only, allowing for the higher of the comparative methods, the ROM which is \$300.00. Thus, the MAR for the 99456-W5-WP is \$650.00 and the MAR for 99456-MI is \$50.00.

3. The respondent has reimbursed a zero dollar amount for the disputed CPT code 99456-W5-WP or CPT code 99456-MI. Therefore, the requestor is entitled to reimbursement of \$700.00.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$700.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$700.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### Authorized Signature

_____	_____	March 07, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**